Subparts S–T—[Reserved]

Subpart U—Health Care Prepayment Plans

SOURCE: 50 FR 1375, Jan. 10, 1985, unless otherwise noted.

§ 417.800 Payment to HCPPs: Definitions and basic rules.

(a) *Definitions.* As used in this subpart, unless the context indicates otherwise—

Covered Part B services means physicians' services, diagnostic X-ray tests, laboratory, other diagnostic tests, and any additional medical and other health services, that the HCPP furnishes to its Medicare enrollees.

Health care prepayment plan (HCPP) means an organization that—

(1) Is responsible for the organization, financing and delivery of covered Part B services to a defined population on a prepayment basis;

(2) Meets the conditions specified in paragraph (b) of this section; and

(3) Elects to be reimbursed on a reasonable cost basis.

Medicare enrollee means a beneficiary under Part B of Medicare who has been identified on HCFA records as an enrollee of the HCPP. *Reporting period* means the period specified by HCFA for which an HCPP must report its costs and utilization.

(b) *Qualifying conditions.* (1) Except as provided in paragraph (b)(2) of this section, an organization wishing to participate as an HCPP must—

(i) Enter into a written agreement with HCFA as specified in § 417.801;

(ii) Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association or individual physicians; and

(iii) Furnish covered Part B services to its Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of title XVIII of the Social Security Act and section 353 of the PHS Act.

(2) An organization that, as of January 31, 1983, was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1) of this section, may receive reimbursement on a reasonable cost basis as an HCPP, provided it files an agreement with HCFA as required by § 417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this subpart, HCFA pays an HCPP on the basis of the reasonable cost it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(2) *Payment for Part B services: Basic rules.* (i) *Cost basis payment.* Except as provided in paragraph (d) of this section, HCFA pays an HCPP on the basis of the reasonable costs it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(ii) *Deductions.* In determining the amount due an HCPP for covered Part B services furnished to its Medicare enrollees, HCFA deducts, from the reasonable cost actually incurred by the HCPP, the following:

(A) The actuarial value of the Part B deductible.

(B) An amount equal to 20 percent of the cost incurred for any service that is subject to the Medicare coinsurance.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. HCFA makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see parts 412 and 413 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. HCFA makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* HCFA makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the

beneficiary assigns his rights to payment in accordance with § 424.55 of this chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

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§ 417.801 Agreements between HCFA and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in § 417.800, an organization must enter into a written agreement with HCFA.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this subpart U must have entered into a written agreement with HCFA within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in § 417.800;

(2) Not charge the Medicare enrollee or any other person for items or services for which that enrollee is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the enrollee is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in § 417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals;

(5) Meet the advance directives requirements specified in § 417.436(d) of this part;

(6) Establish administrative review procedures in accordance with §§ 417.830 through 417.840 for Medicare enrollees who are dissatisfied with denied services or claims; and

(7) Consider any additional requirements that HCFA finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the initial agreement is set by HCFA.

(d) *Termination or nonrenewal of agreement by HCFA.* (1) HCFA may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in § 417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable HCFA regulations, or applicable provisions of the Medicare law; or

(iii) The HCPP undergoes a change in ownership as specified in subpart M of this part.

(2) HCFA will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to HCFA at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with HCFA stating the intended effective date of termination.

(2) HCFA may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. HCFA makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

(ii) Otherwise interfere with the efficient administration of the Medicare program.

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